



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH HEB
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name

TEXTRON INC

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-2041-01

MFDR Date Received

February 22, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medicare would have reimbursed the provider at the base APC rate of \$2,100.29 for APC # 0154. Allowing this at 200% would yield a fair and reasonable allowance of \$4,200.58. Also Medicare would have reimbursed the provider at the base APC rate of \$2,100.29 for APC # 0154. Allowing this at 200% would yield a fair and reasonable allowance of \$4,200.58, but per the multiply procedure rule the correct allowable would be at 50% making the allowable \$2,100.29... Also the implants were not carved out for payment in box 80, so this claim should pay at the full amount due..."

Amount in Dispute: \$2,100.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor has failed to properly submit its fees in accordance with Division Rules. The charges were audited, and payment was issued in accordance with the documentation submitted and in accordance with the explanation of reviews. Requestor has failed to indicate a clear basis for additional reimbursement."

Response Submitted by: Burns Anderson Jury & Brenner, LLP, PO Box 26300, Austin, Texas 78755-6300

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2010 to March 29, 2010	Outpatient Hospital Services	\$2,100.28	\$897.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 147 – Provider contracted/negotiated rate expired or not on file.
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). \$0.00
 - W1 – Workers Compensation State Fee Schedule Adjustment \$0.00
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 - 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE
 - 595-003 – REIMBURSEMENT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE STATE SPECIFIED PERCENTAGE INCREASE AND IMPLANTABLE CARVE OUT.
 - 595-004 – THE ALLOWANCE FOR THIS LINE HAS BEEN SUMMED WITH OTHER ALLOWANCES ON THE BILL AND RE-DISTRIBUTED EVENLY.
 - 670-007 – REIMBURSEMENT IS BASED ON THE PROVIDERS REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.
 - 857 – PROCEDURE INCLUDED IN ANOTHER CODE BILLED ON THE SAME DATE OF SERVICE \$0.00
 - 857-000 – CPT/NOC/HCPC/ICD-9 CODES REQUIRED FOR REIMBURSEMENT. PLEASE RESUBMIT WITH APPROPRIATE CODE(S). \$0.00
 - 983-001 – UPON FURTHER REVIEW-ADDITIONAL PAYMENT IS WARRANTED.
 - 900-001 – O-DENIAL AFTER RECONSIDERATION BASED ON FURTHER REVIEW, NO PAYMENT IS WARRANTED.
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 147 – “Provider contracted/negotiated rate expired or not on file,” and 45 – “Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). \$0.00”. No network reduction is indicated on the explanations of benefits. No documentation was found to support a contractual agreement between the parties to this dispute. These reason codes are therefore not supported.

Additionally, the insurance carrier denied disputed services with reason codes 595-003 – “REIMBURSEMENT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE STATE SPECIFIED PERCENTAGE INCREASE AND IMPLANTABLE CARVE OUT” and 670-007 – “REIMBURSEMENT IS BASED ON THE PROVIDERS REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.” Although the provider did attach invoices marked “*IMPLANT INVOICE*” and did stamp the invoice with a certification of “true and correct actual cost”, no documentation was found to support that the health care provider requested separate reimbursement for implantables. These reason codes are not supported.

Moreover, the respondent's position statement enumerates a number of new defenses or reasons for denial that were not presented to the requestor prior to the date the request for MFDR was filed. Per 28 Texas Administrative Code §133.307(d)(2)(B), “The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.”

The Division concludes that the respondent has not supported the above denial reasons. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective

Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
- Procedure code C1781 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services §134.203. The fee listed for this code in the applicable Medicare fee schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
 - Procedure code 84132 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services §134.203. The fee listed for this code in the applicable Medicare fee schedule is \$6.58. 125% of this amount is \$8.22. The recommended payment is \$8.22.
 - Procedure code 49565 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0154, which, per OPPS Addendum A, has a payment rate of \$2,154.85. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,292.91. This amount multiplied by the annual wage index for this facility of 0.9578 yields an adjusted labor-related amount of \$1,238.35. The non-labor related portion is 40% of the APC rate or \$861.94. The sum of the labor and non-labor related amounts is \$2,100.29. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$2,100.29. This amount multiplied by 200% yields a MAR of \$4,200.58.
 - Procedure code 49568 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0154, which, per OPPS Addendum A, has a payment rate of \$2,154.85. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,292.91. This amount multiplied by the annual wage index for this facility of 0.9578 yields an adjusted labor-related amount of \$1,238.35. The non-labor related portion is 40% of the APC rate or \$861.94. The sum of the labor and non-labor related amounts is \$2,100.29. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,050.14. This amount multiplied by 200% yields a MAR of \$2,100.29.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2550 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no

separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 93005 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$26.56. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.94. This amount multiplied by the annual wage index for this facility of 0.9578 yields an adjusted labor-related amount of \$15.26. The non-labor related portion is 40% of the APC rate or \$10.62. The sum of the labor and non-labor related amounts is \$25.89. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$25.89. This amount multiplied by 200% yields a MAR of \$51.78.
5. The total recommended payment for the billed services is \$6,364.62. This amount less the amount previously paid by the insurance carrier of \$5,467.27 leaves an amount due to the requestor of \$897.35.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$897.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$897.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>May 24, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.